

1 EDMUND G. BROWN JR., Attorney General
of the State of California
2 ARTHUR TAGGART
Supervising Deputy Attorney General
3 JEFFREY M. PHILLIPS, State Bar No. 154990
Deputy Attorney General
4 California Department of Justice
1300 J Street, 19th Floor
5 P.O. Box 944255
Sacramento, CA 94244-2550
6 Telephone: (916) 324-6292
Facsimile: (916) 327-8643

7 Attorneys for Complainant
8

9 **BEFORE THE**
BOARD OF REGISTERED NURSING
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 2009-108

13 **SHANNON R. STROMBERG, AKA**
14 **SHANNON RANAE STROMBERG, AKA**
SHANNON AITKEN
3010 Avenue G
15 White City, OR 97503

A C C U S A T I O N

16 Registered Nurse License No. 703127

17 Respondent.

18 Complainant alleges:

19 **PARTIES**

20 1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation
21 solely in her official capacity as the Executive Officer of the Board of Registered Nursing
22 ("Board"), Department of Consumer Affairs.

23 **Registered Nurse License**

24 2. On or about May 4, 2007, the Board issued Registered Nurse License
25 Number 703127, to Shannon R. Stromberg, also known as Shannon Ranae Stromberg, and
26 Shannon Aitken ("Respondent"). The registered nurse license will expire on November 30,
27 2008, unless renewed.

28 //

1

2

6

1

2

6

9

O

1

3

4

6

1 (b) Use any controlled substance as defined in Division 10
2 (commencing with Section 11000) of the Health and Safety Code, or any
3 dangerous drug or dangerous device as defined in Section 4022, or alcoholic
4 beverages, to an extent or in a manner dangerous or injurious to himself or herself,
5 any other person, or the public or to the extent that such use impairs his or her
6 ability to conduct with safety to the public the practice authorized by his or her
7 license.

8 (e) Falsify, or make grossly incorrect, grossly inconsistent, or
9 unintelligible entries in any hospital, patient, or other record pertaining to the
10 substances described in subdivision (a) of this section.

11 8. Code section 4060 provides, in pertinent part,

12 No person shall possess any controlled substance, except that furnished to
13 a person upon the prescription of a physician, dentist, podiatrist, optometrist,
14 veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished
15 pursuant to a drug order issued by a certified nurse-midwife pursuant to Section
16 2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant
17 pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a
18 pharmacist pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv)
19 of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052.

20 9. Health and Safety Code section 11173, subdivision (a), provides:

21 No person shall obtain or attempt to obtain controlled substances, or
22 procure or attempt to procure the administration of or prescription for controlled
23 substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the
24 concealment of a material fact.

25 COST RECOVERY

26 10. Code section 125.3 provides, in pertinent part, that the Board may request
27 the administrative law judge to direct a licensee found to have committed a violation or
28 violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation
and enforcement of the case.

29 DRUGS

30 11. "Demerol," a brand of meperidine hydrochloride, a derivative of
31 pethidine, is a Schedule II controlled substance as designated by Health and Safety Code section
32 11055, subdivision (c)(17), and is a dangerous drug within the meaning of Code section 4022, in
33 that under federal law it requires a prescription.

34 12. "Dilaudid," a brand of hydromorphone, is a Schedule II controlled
35 substance as designated by Health and Safety Code section 11055(b)(1)(K), and is a dangerous

1 drug within the meaning of Code section 4022, in that under federal law it requires a
2 prescription.

3 13. **"Morphine"** is a Schedule II controlled substance as designated by Health
4 and Safety Code section 11055, subdivision (b)(1)(M), and is a dangerous drug within the
5 meaning of Code section 4022, subdivision (a), in that under federal law it requires a
6 prescription.

7 14. **"Percocet"**, a brand of oxycodone, is a Schedule II controlled substance as
8 designated by Health and Safety Code section 11055, subdivision (b)(1)(N), and is a dangerous
9 drug within the meaning of Code section 4022, in that under federal law it requires a
10 prescription.

11 15. **"Vicodin"** is a compound consisting of 5 mg. hydrocodone bitartrate also
12 known as dihydrocodeinone, a Schedule III controlled substance as designated by Health and
13 Safety Code section 11056, subdivision (e)(4), and 500 mg. acetaminophen per tablet , and is a
14 dangerous drug within the meaning of Code section 4022, in that under federal law it requires a
15 prescription.

16 **FIRST CAUSE FOR DISCIPLINE**

17 (Obtain and Possess Controlled Substances in Violation of Law, and Self-Administer)

18 16. Respondent's registered nurse license is subject to disciplinary action
19 under Code section 2761, subdivision (a), on the grounds of unprofessional conduct as defined in
20 Code section 2762, subdivision (a), as follows:

21 **Modoc Medical Center:** Between on or about April 9, 2007, and May 15, 2007,
22 while working as a registered nurse at Modoc Medical Center in Alturas, California, Respondent
23 did the following:

24 a. Respondent obtained Percocet, Demerol, Morphine, and Vicodin,
25 controlled substances, by fraud, deceit, misrepresentation or subterfuge, or the concealment of a
26 material fact, in violation of Health and Safety Code section 11173, subdivision (a), by taking the
27 drug from hospital supplies for her own personal use.

28 //

1 b. Respondent possessed Percocet, Demerol, Morphine, and Vicodin,
2 controlled substances, in violation of Code section 4060.

3 c. Respondent self-administered Percocet and Demerol, controlled
4 substances, without direction from a licensed physician, surgeon, dentist or podiatrist.

5 **Palomar Medical Center:** Between on or about July 4, 2007, and August 10,
6 2007, while working as a registered nurse at Palomar Medical Center in Escondido, California,
7 Respondent did the following:

8 d. Respondent obtained Dilaudid, a controlled substance, by fraud, deceit,
9 misrepresentation or subterfuge, or the concealment of a material fact, in violation of Health and
10 Safety Code section 11173, subdivision (a), by taking the drug from hospital supplies for her own
11 personal use.

12 e. Respondent possessed Dilaudid, a controlled substance, in violation of
13 Code section 4060.

14 **SECOND CAUSE FOR DISCIPLINE**

15 (Use of Drugs - Danger to Others)

16 17. Respondent's registered nurse license is subject to disciplinary action
17 under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined
18 in Code section 2762, subdivision (b), in that between April 9, 2007, and May 15, 2007, while on
19 duty as a registered nurse at Modoc Medical Center, Respondent used Percocet and Demerol,
20 controlled substances, to an extent or in a manner dangerous or injurious to herself or others, as
21 more fully set forth in paragraph 16, subparagraph b, above.

22
23 **THIRD CAUSE FOR DISCIPLINE**

24 (False, Grossly Inconsistent or Unintelligible Entries in Hospital or Patient Records)

25 18. Respondent's registered nurse license is subject to disciplinary action
26 under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined
27 in Code section 2762, subdivision (e), as follows:

28 //

1 **Modoc Medical Center:** Between on or about April 9, 2007, and May 15, 2007,
2 while working as a registered nurse at Modoc Medical Center in Alturas, California, Respondent
3 falsified or made grossly incorrect entries in hospital or patient records, including but not limited,
4 to the following:

5 **Patient A-01**

6 a. On or about April 15, 2007, at 2015, and 2030 hours, Respondent charted
7 the administration of 4 mg. of Morphine each time to this patient without a physician's order.

8 b. On or about April 15, 2007, at 2100 hours, Respondent charted the
9 administration of 50 mg. of Demerol to this patient. On April 15, 2007, at 2245 hours, and on
10 April 16, 2007, at 0515 hours, Respondent charted the administration of 25 mg. of Demerol to
11 this patient, exceeding the physician's order for 25 mg. of Demerol every four hours.

12 **Patient A-02**

13 c. On or about April 19, 2007, at 2230 hours, Respondent signed out 100 mg.
14 of Demerol for this patient without a physician's order, and failed to chart the administration or
15 wastage of the Demerol in any patient or hospital record or otherwise account for the disposition
16 of the drug.

17 **Patient A-03**

18 d. On or about April 21, 2007, at 0120 hours, Respondent signed out 100 mg.
19 of Demerol for this patient, without a physician's order, and documented the wastage of 50 mg.
20 of Demerol. Respondent failed to chart the administration of the 50 mg. of the remaining
21 Demerol in any patient or hospital record or otherwise account for the disposition of the drug.

22 **Patient A-04**

23 e. On or about April 19, 2007, at 1900 hours, Respondent charted the
24 administration of 10 mg. of Morphine to this patient, yet failed to document its withdrawal.

25 f. On or about April 20, 2007, at 2030 and 2305 hours, Respondent signed
26 out 10 mg. of Morphine for this patient each time and administered 6 mg. of Morphine to this
27 patient each time. Respondent documented the wastage of 4 mg. of the remaining Morphine
28 each time without a co-signer.

1 g. On or about April 21, 2007, at 0530 hours, Respondent signed out 10 mg.
2 of Morphine for this patient, charted administration of 6 mg. of Morphine to this patient, and
3 documented the wastage of 4 mg. of Morphine without a co-signer.

4 h. On or about April 22, 2007, at 1245 hours, Respondent signed out on the
5 same line of the narcotics log for 10 mg. of Morphine and 100 mg. of Demerol for this patient
6 and documented the wastage of the drugs without a co-signer. There was no physician's order
7 for Demerol for this patient.

8 **Patient A-05**

9 i. On or about April 26, 2007, at 1645 hours, Respondent signed out 100 mg.
10 of Demerol for this patient without a physician's order, and failed to chart the administration of
11 the Demerol in any patient or hospital record or otherwise account for the disposition of the drug.

12 **Patient A-06**

13 j. On or about April 30, 2007, at 0130 hours, Respondent signed out 10 mg.
14 of Morphine for this patient and documented the wastage of 6 mg. of Morphine without a co-
15 signer. Respondent charted the administration of 4 mg. of Morphine to this patient on *April 29,*
16 *2007*, at 0130 hours.

17 k. On or about April 30, 2007, at 1915 hours, Respondent signed out 100 mg.
18 of Demerol for this patient without a physician's order. Respondent failed to chart the
19 administration of the Demerol in any patient or hospital record or otherwise account for the
20 disposition of the drug.

21 l. On or about April 30, 2007, at 0530 hours, Respondent signed out 10 mg.
22 of Morphine for this patient without a physician's order. Respondent failed to chart the
23 administration of the Morphine in any patient or hospital record or otherwise account for the
24 disposition of the drug.

25 **Patient A-07**

26 m. On or about May 3, 2007, at 0340 hours, Respondent signed out 4 mg. of
27 Morphine for this patient, yet charted that she administered the drug on *May 2, 2007*, at 0340
28 hours.

1 n. On or about May 3, 2007, at 0220 hours, Respondent signed out 10 mg. of
2 Morphine for this patient, yet charted that she administered 4 mg. of Morphine on *May 2, 2007*,
3 at 2215 hours. Respondent failed to chart the administration of the 6 mg. of the remaining
4 Morphine in any patient or hospital record or otherwise account for the disposition of the drug.

5 o. On or about May 3, 2007, at 1920 hours, Respondent signed out 6 Vicodin
6 5/500 tablets for this patient, yet failed to chart the administration of the Vicodin in any patient or
7 hospital record or otherwise account for the disposition of the drug.

8 **Patient A-08**

9 p. On or about May 2, 2007, at 2315 hours, Respondent signed out 100 mg.
10 of Demerol for this patient without a physician's order. Respondent documented the wastage of
11 50 mg. of the Demerol, but failed to chart the administration of the 50 mg. of the remaining
12 Demerol in any patient or hospital record or otherwise account for the disposition of the drug.

13 **Patient A-09**

14 q. On or about May 4, 2007, at 0010 hours, Respondent signed out 100 mg.
15 of Demerol for this patient without a physician's order. Respondent failed to chart the
16 administration of the Demerol in any patient or hospital record or otherwise account for the
17 disposition of the drug.

18 r. On or about May 4, 2007, at 0200 hours, Respondent signed out 10 mg. of
19 Morphine for this patient and documented its wastage. This patient did not have a physician's
20 order for Morphine.

21 s. On or about May 4, 2007, at 2300 hours, Respondent signed out 100 mg.
22 of Demerol for this patient without a physician's order. Respondent failed to chart the
23 administration of the Demerol in any patient or hospital record or otherwise account for the
24 disposition of the drug.

25 **Patient A-10**

26 t. On or about May 4, 2007, at 1700 hours, Respondent signed out 10 mg. of
27 Morphine for this patient without a physician's order. Respondent failed to chart the
28 administration of the Morphine in any patient or hospital record or otherwise account for the

1 disposition of the drug.

2 **Patient A-11**

3 u. On or about May 5, 2007, at 0230 hours, Respondent signed out 100 mg.
4 of Demerol for this patient without a physician's order for Demerol, and documented its wastage.

5 v. On or about May 5, 2007, at 0300 hours, Respondent signed out 10 mg. of
6 Morphine for this patient without a physician's order for Morphine, and documented the wastage
7 of 5 mg. of the Morphine. Respondent failed to chart the administration of the 5 mg. of the
8 remaining Morphine in any patient or hospital record or otherwise account for the disposition of
9 the drug.

10 **Patient A-12**

11 w. On or about May 6, 2007, at 1400, 1425, 1455, and 1528 hours,
12 Respondent signed out 4 mg. of Morphine each time, charted the administration of 2 mg. of
13 Morphine to this patient each time, and documented the wastage of 2 mg. of Morphine each time
14 without a co-signer.

15 x. On or about May 6, 2007, at 1528 hours, Respondent signed out 10 mg. of
16 Morphine for this patient. Respondent failed to chart the administration of the Morphine in any
17 patient or hospital record or otherwise account for the disposition of the drug.

18 y. On or about May 7, 2007, at 1940 and 2115 hours, Respondent signed out
19 10 mg. of Morphine each time and documented the wastage of 2 mg. of Morphine each time.
20 Respondent charted the administration of 2 mg. of morphine to this patient on May 7, 2007, at
21 1940, 2100, 2210, 2300, and 0000 hours, totaling 10 mg. administered. Respondent failed to
22 chart the administration of 12 mg. of the remaining Morphine in any patient or hospital record or
23 otherwise account for the disposition of the drug.

24 z. On or about May 8, 2007, at 0200 and 0500 hours, Respondent signed out
25 10 mg. of Morphine each time for this patient and documented the wastage of 2 mg. of Morphine
26 at 0500 hours. Respondent charted the administration of 2 mg. of Morphine to this patient on
27 May 8, 2007, at 0100, 0200, 0300, 0400, 0500, 0600, and 0700 hours, totaling 14 mg. of
28 Morphine administered. Respondent failed to chart the administration of 4 mg. of the remaining

1 Morphine in any patient or hospital record or otherwise account for the disposition of the drug.

2 **Patient A-13**

3 aa. On or about May 6, 2007, Respondent signed out 100 mg. of Demerol for
4 this patient without a physician's order. Respondent documented wastage of 75 mg. of Demerol
5 but failed to document the time of the withdrawal or the wastage, and failed to chart the
6 administration of the remaining drug in any patient or hospital record or otherwise account for
7 disposition of the drug.

8 **Patient A-14**

9 ab. On or about May 8, 2007, at 0115 hours, Respondent signed out 10 mg. of
10 Morphine for this patient without a physician's order. Respondent documented the wastage of 4
11 mg. of the Morphine, but failed to chart the administration of the 6 mg. of the remaining
12 Morphine in any patient or hospital record or otherwise account for the disposition of the drug.

13 **Patient No. A-15**

14 ac. On or about May 11, 2007, at 1950 hours, Respondent signed out 100 mg.
15 of Demerol for this patient and documented the wastage of 50 mg. of Demerol without a co-
16 signer. Respondent failed to chart the administration of the 50 mg. of the remaining Demerol in
17 any patient or hospital record or otherwise account for the disposition of the drug.

18 **Patient No. A-16**

19 ad. On or about May 11, 2007, at 2120 hours, Respondent signed out 10 mg.
20 of Morphine for this patient without a physician's order, and documented the wastage of 4 mg. of
21 the Morphine without a co-signer. Respondent failed to chart the administration of the 6 mg. of
22 the remaining Morphine in any patient or hospital record or otherwise account for the disposition
23 of the drug.

24 **Patient No. A-17**

25 ae. On or about May 12, 2007, at 2055 hours, Respondent charted the
26 administration of 10 mg. of Morphine to this patient. Twenty minutes later, at 2115 hours,
27 Respondent signed out 10 mg. of Morphine for this patient without a physician's order, and
28 documented its wastage without a co-signer.

1 af. On or about May 12, 2007, at 2145 hours, Respondent signed out 100 mg.
2 of Demerol for this patient, charted the administration of 50 mg. of Demerol to this patient at
3 2143 hours, and documented the wastage of 50 mg. of Demerol without a co-signer.

4 **Patient No. A-18**

5 ag. On or about May 12, 2007, Respondent signed out 10 mg. of Morphine for
6 this patient without a physician's order, and documented the wastage of 5 mg. of the Morphine
7 without a co-signer. Respondent failed to document the time of the withdrawal and wastage, and
8 failed to chart the administration of the 5 mg. of the remaining Morphine in any patient or
9 hospital record or otherwise account for the disposition of the drug.

10 **Patient No. A-19**

11 ah. On or about May 13, 2007, at 2000 hours, Respondent signed out 15 mg.
12 of Morphine for this patient without a physician's order. Respondent failed to chart the
13 administration of the drug in any patient or hospital record or otherwise account for the
14 disposition of the drug.

15 ai. On or about May 13, 2007, at 2000 hours, Respondent signed out 100 mg.
16 of Demerol for this patient, without a physician's order, and documented its wastage without a
17 co-signer.

18 aj. On or about May 13, 2007, at 2015 hours, Respondent signed out 6 tablets
19 of Percocet for this patient without a physician's order. Respondent failed to chart the
20 administration of the drug in any patient or hospital record or otherwise account for the
21 disposition of the drug.

22 **Patient No. A-20**

23 ak. On or about May 13, 2007, at 2030 hours, Respondent signed out 15 mg.
24 of Morphine for this patient without a physician's order. Respondent failed to chart the
25 administration of the drug in any patient or hospital record or otherwise account for the
26 disposition of the drug.

27 //

Patient No. A-21

al. On or about May 15, 2007, at 2050 hours, Respondent signed out 6 tablets of Percocet for this patient without a physician's order. Respondent failed to chart the administration of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

Patient No. A-22

am. On or about May 15, 2007, at 2040 hours, Respondent signed out 6 5/500 tablets of Vicodin for this patient without a physician's order. Respondent failed to chart the administration of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

an. On or about May 15, 2007, at 2100 hours, Respondent signed out 15 mg. of Morphine for this patient without a physician's order. Respondent failed to chart the administration of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

Patient No. A-23

ao. On or about May 15, 2007, at 2010 hours, Respondent signed out 75 mg. of Demerol for this patient. At 2015, Respondent charted the administration of 75 mg. of Demerol to this patient. At 2040 hours, Respondent signed out 100 mg. of Demerol for this patient and wasted 50 mg. of the Demerol without a co-signer. At 2045 hours, Respondent charted the administration of 50 mg. of Demerol to this patient. Respondent's withdrawals of Demerol for this patient exceeded the physician's order for 125 mg. of Demerol.

ap. On or about May 15, 2007, at 2100 hours, Respondent signed out 100 mg. of Demerol for this patient without a physician's order. Respondent failed to chart the administration of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

//

1 **Patient No. A-24**

2 aq. On or about May 15, 2007, at 2300 hours, Respondent signed out 100 mg.
3 of Demerol for this patient without a physician's order. Respondent failed to chart the
4 administration of the drug in any patient or hospital record or otherwise account for the
5 disposition of the drug.

6 **Patient No. A-25**

7 ar. On or about April 30, 2007, at 0220 hours, Respondent signed out 10 mg.
8 of Morphine for this patient and wasted 6 mg. of Morphine without a co-signer.

9 **Patient No. A-26**

10 as. On or about May 12, 2007, at 2140 hours, Respondent signed out 100 mg.
11 of Demerol for this patient and wasted 50 mg. of Demerol without a co-signer.

12 **Patient "Jim W"**

13 at. On or about April 29, 2007, at 1350 hours, Respondent signed out 100 mg.
14 of Demerol for "Jim W", who was not a patient of Modoc Medical Center on April 29, 2007.
15 Respondent failed to chart the administration of the Demerol in any patient or hospital record or
16 otherwise account for the disposition of the drug.

17 **Palomar Medical Center:**

18 au. Between on or about July 4, 2007, and August 10, 2007, while working as
19 a registered nurse at Palomar Medical Center in Escondido, California, Respondent falsified or
20 made grossly incorrect entries in hospital or patient records by removing two doses of Dilaudid
21 from the Pyxis machine for this patient, administering one dose of Dilaudid to that patient, and
22 retaining the second dose of Dilaudid for her own personal use.

23 **FOURTH CAUSE FOR DISCIPLINE**

24 (Prescribed and Administered Controlled Substances)

25 19. Respondent's registered nurse license is subject to disciplinary action
26 under Code section 2761, subdivision (a), on the grounds of professional conduct as defined in
27 Code section 2762, subdivision (a), in that between April 9, 2007, and May 15, 2007, while
28 working as a registered nurse at Modoc Medical Center, in Alturas, California, Respondent

1 unlawfully administered the following controlled substances without direction from a licensed
2 physician, surgeon, dentist or podiatrist:

3 a. Respondent administered Morphine to Patient A-01, as set forth above in
4 paragraph 18, subparagraph a.

5 b. Respondent administered Demerol in excess of the physician's order to
6 Patient A-01, as set forth above in paragraph 18, subparagraph b.

7 **FIFTH CAUSE FOR DISCIPLINE**

8 **(Unprofessional Conduct)**

9 20. Respondent's registered nurse license is subject to disciplinary action
10 under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, in that
11 between April 9, 2007 and May 15, 2007, while on duty as a registered nurse at Modoc Medical
12 Center in Alturas, California, Respondent committed acts constituting unprofessional conduct, as
13 set forth in paragraph 18, subparagraph a through au, above.

14 **PRAYER**


15 **WHEREFORE**, Complainant requests that a hearing be held on the matters
16 herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

17 1. Revoking or suspending Registered Nurse License Number 703127, issued
18 to Shannon R. Stromberg, also known as Shannon Ranae Stromberg, and Shannon Aitken;

19 2. Ordering Shannon R. Stromberg, also known as Shannon Ranae
20 Stromberg, and Shannon Aitken, to pay the Board of Registered Nursing the reasonable costs of
21 the investigation and enforcement of this case, pursuant to Code section 125.3; and,

22 3. Taking such other and further action as deemed necessary and proper.

23 DATED: 11/17/08

24 
RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant